Intra-uterine Hydrocephalus; Breech Presentation; Delivery with the Forceps. By S. B. BIBIGHAUS, M.D., of Middlebury, Pa.

I am induced to report this case, as similar ones are very rare. With the exception of the two cases presented by Dr. Corse to the College of Physicians of Philadelphia, and published in the *American Journal of the Medical Sciences* for January, 1861, and January, 1863 (delivery accomplished in both cases by ovariotomy), I know of no others, and have myself met with no other in a practice of nearly twenty years.

The above reasons, with the successful issue in my case with the forceps, induce me to place it on record.

Mrs. J. S., aged about 35 years, is the mother of three children, all living. The oldest daughter menstruated at the unusual age of six years, rendering her delicate. At the time of her birth the mother had a severe attack of convulsions, which I checked by large bleedings.

On the 23d of August, 1874, at noon, I was sent for, and found Mrs. J. S. in labour, the os dilating, and pains gradually increasing. About 3 o'clock P. M. I made another examination, and found the breech presenting. I told her husband that on this account her labour would be prolonged. The body of the infant was born about 4 o'clock P. M., with the head resting on the brim of the pelvis; discovered it to be very large; the fontanelles were of unusual size, and the space between the sutures very wide, showing that I had a serious and rare case to deal with, and, in the language of Dr. Corse, "complicating labour very much."

I gave her small portions of ergot, and putting my finger into the child's mouth, tried to bring down the head, but I was disappointed. Finding the woman becoming exhausted by the continual pains and irritation, I at once sent for my forceps, chloroform, and assistance.

At 5 o'clock the messenger and Dr. J. W. Rockerfeller arrived. I very soon brought her under the effects of the chloroform, when the long forceps were applied.

We found great difficulty in adjusting the instruments, and in preventing them from slipping off; but by persevering and powerfully compressing the head, we found, to our great relief, that the head was moving slowly. After working hard for about an hour the head was born.

I am sorry that I did not measure the head, for it would be more satisfactory; yet I do not believe it would fall far short of Dr. Corse's case.

The mother made a good recovery.

April 28, 1875.

Dysentery treated by Posture. By C. B. GALENTINE, M.D., of Cleveland, Ohio.

The horizontal or an elevated position is notably essential in the treatment of many surgical diseases, as well as those of an exclusive medical character.

For years past I had occasional attacks of dysentery, attended by that unendurable sense of congestive fulness, pain, and constant desire to sit and strain which writers most fitly denominate *tenesmus* and *tormina*. The discharge of a little blood and much mucus brings no relief, but rather an increase of the tormina.

In the midst of such suffering as only comes from an attack of dysentery, I felt that in some way the weight of the superincumbent bowels must be removed, and the current of the blood in some way be dammed up or inverted to take off the insufferable pressure from the rectum. Being

slightly under the influence of opium, as by its inspiration, I quickly changed my hips to the head of the lounge, elevating them to an angle of thirty or forty degrees above the trunk. Almost in an instant I felt relief, which was followed in a day or two by complete recovery.

In subsequent attacks it has been equally efficacious, and, as a result, has become with me a standard item of treatment.

After two years or more of experience and observation of its benefits, I can say I regard it the *chief* item of treatment in acute dysentery, and that, were I limited to one remedy, that would be the position I have indicated.

It may be thought that the position itself would be uncomfortable and poorly borne by the patient. I reply, anything is comfortable and endurable that relieves from the torments of dysentery—besides my experience indicates that the position need not be maintained any great length of time—say from one to four hours as often as the pressure or tenesmus returns. In experience during an attack recently the posture was not only *endurable*, but luxuriously enjoyable. Lay a book or a small, hard pillow under the head, leaving the hips and legs raised, and a patient never complains.

In all ordinary attacks, aided by small anodynes per rectum or per orem, I believe the treatment above indicated will be found all-sufficient, and, with me, in no supposable case can it well be ignored.

Entrance of Air into Divided Internal Jugular Veins; Ligation; Recovery. By A. B. TADLOCK, A.M., M.D., of Knoxville, Tenn.

On the 1st of February, 1875, I was summoned in great haste to see a man, two squares distant from my office, "who had his throat cut," as the informant excitedly said. I started to follow, but was delayed a few minutes. The wounded man received the injury over half a square distant, and had walked with help to the location where I found him and Dr. Stewart, who had sent for me in consultation. The patient is a coloured man, aged 30, weighs over two hundred pounds, large and fleshy, a good specimen of health, and is a blacksmith by trade. He was sitting on steps, leaning forward, with head resting on the right hand, and elbow supported on the right knee; left shoulder drawn up and head bent towards it. Dr. S. had found this position favourable to checking the flow, and was admonishing the patient to "compose himself and be quiet;" nevertheless the weakness of the pulse and exsanguine appearance indicated great loss of blood, besides, his shirt was saturated, and frightful streams still ran down his neck and chest.

With a razor in the hands of the attacking party two transverse and nearly parallel incisions had been made across the left side of the neck, four inches long and about one and a half inch apart. The upper one, ranging with the inferior maxillary, severed the skin, fascia, platysma, and sterno-cleido-mastoid muscles, the external jugular, the posterior external jugular, and anterior jugular veins, and the superior thyroid artery. The other cut, began near the median line, one inch or less above the sterno-clavicular articulation, with a deep thrust, and extending across and backwards, divided the superficial parts above mentioned, together with the omo-hyoid muscle, and wounding the sterno-thyroid and trapezoid muscles, also severed the superficial cervical artery, made an opening into the trachea, and cut about half through the internal jugular vein.

Having the patient taken in immediately and placed on a lounge, I